Local Partnerships for Community Assessment and Planning

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Purpose: Community assessment is a core function of public health. National and state policies encourage local health departments (LHDs) to engage local partners in conducting community assessments. This study examined the prevalence, characteristics, and effectiveness of community assessment partnerships between LHDs and other organizations. **Methods:** LHDs in Wisconsin completed a 2-stage, cross-sectional survey. A subset analysis of community assessment partnerships was conducted using descriptive, bivariate, and multivariate statistical methods. **Results:** Ninety percent of LHDs reported a partnership focused on community assessment ($n = 69$). Sixty-six percent of community assessment partnerships had existed for three or more years, and all of these had implemented plans ($n = 43$). Community assessment partnerships were more likely than partnerships focused on other issues to have formed because of a mandate, to include many partners, and to receive some forms of financial support from the LHD. Partnerships focused on community assessment were no more likely to be effective than other types of partnerships. **Conclusions:** LHDs and community partners realize mutual benefits from collaborating on community assessment. Successful community assessment partnerships can be supported by building competencies in the public health workforce and sustaining partnerships for substantial periods of time.

KEY WORDS: community health planning, needs assessment, public health administration

Assessing the health of a community was identified as one of the core functions of public health in the Institute of Medicine's *The Future of Public Health*.[1] Assessment partnerships are encouraged in *Healthy People 2010* and in state-level public health improvement plans such as *Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public*.[2,3] The National Public Health Performance Standards Program indicates that partners from throughout the local public health system should collaborate in assessing a community's health needs, and participants should include representatives from organizations that contribute to the delivery of public health services in the community.[4] According to a study by the National Association of County and City Health Officials (NACCHO), the majority of local public health agencies in the nation collaborate with partners in the development of a community health improvement plan.[5]

Research on the frequency and types of local health department (LHD) community assessment and planning (CAP) partnerships is limited. However, there is a great deal of information on factors that contribute to a successful collaboration between different public organizations, and how to conduct a successful community health assessment. Themes from the few LHDs that published their community health assessment strategies included using the community itself as a partner to gather primary data,[6–8] and partnering with other governmental health agencies.[9,10] Other interorganizational community health assessments were done between state and county public health agencies, health maintenance organizations, hospitals, universities and academic centers, faith communities, and other public agencies.[5,11–14] Factors cited by these organizations that led to a successful CAP partnership included ongoing

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communication, funding, community outreach networks, time, and common goals. Partnerships also reported using tools that support CAP partnerships, such as the Assessment Protocol for Excellence in Public Health and Mobilizing for Action through Partnership and Planning (MAPP).[9,15]

A survey of LHDs in Wisconsin was conducted in 2002 to 2003. The survey explored the prevalence, characteristics, and effectiveness of partnerships between LHDs and other organizations.[16] The article describes CAP partnerships, examines measures of their success, and compares them to partnerships focused on all other problem areas.

Methods

Human subjects approval

This project was determined to be exempt under 45 CFR 46.101(b)(2) by the Institutional Review Board at University of Wisconsin – Madison.

Data collection

Data were collected through two cross-sectional surveys of LHD directors or their designees. The first survey was conducted electronically using the Wisconsin Health Alert Network and identified the number of CAP partnerships in the state. Each LHD reporting a CAP was subsequently sent a second survey to collect more detailed information about the CAP partnership. A full description of the data collection methods has been previously reported.[16] The definition of partnership provided to participants was, "Collaborative, synergistic alliances that include the LHD and one or more other public health system partners, which work to improve health and/or healthcare services in an identified need or problem area and in an identified geographic area." CAP partnerships were identified by respondents' checking the option of "community assessment and planning" from a list of 21 options for the primary focus of the local public health system partnership.

Study variables

Partnership characteristics studied included types of activities conducted by the CAP, length of time the CAP had existed, reason for partnership formation, types of organizations involved, number of different types of organizations in the CAP, the geographic focus for the partnership, the extent to which partners contributed financially to the partnership, the type of financial support provided by the LHD, and the existence of a budget. Organizational characteristics of the LHD examined included rural or urban jurisdiction, county or subcounty jurisdiction, human services or independent health department structure, and certification level of the LHD (Level 1, 2, or 3).[17] Certification level corresponds with LHD complexity of services: Level 1 agencies provide basic services, Level 2 agencies provide basic plus additional services guided by the state health plan, and Level 3 agencies provide a full range of public health services. Outcome variables included whether any of the partnership plans had been implemented (yes or no) and extent of success in implementing CAP partnership plans using a 1 to 4 scale (1 = very unsuccessful; 4 = very successful) that also was dichotomized in the analysis.

Data analysis

Survey data were entered into a Stata database for analysis.[18] Descriptive statistical analysis included frequencies and means. Bivariate analyses methods included χ^2, Fisher's exact, and analysis of variance (ANOVA). Ordinary least squares and logistic regression were used to assess impact of independent variables on CAP partnership outcomes. Comparisons between CAP partnerships and all other types of local public health system partnerships also were studied.

Results

Response rates for the two stages of the survey have been previously reported.[16] Analyses are based on 924 partnerships involving 74 LHDs, an overall response rate of 78 percent from all LHDs in Wisconsin ($n = 74$ [of 95]). Partnerships that focused on CAP are described and compared to all other partnerships.

Prevalence and characteristics of CAP partnerships

CAP was a frequently reported primary focus area for local public health system partnerships, ranking fourth in frequency following (1) tobacco prevention and control, (2) maternal and child health promotion, and (3) emergency/bioterrorism preparedness. Most LHDs ($n = 67$, 90%) reported one CAP partnership. Six LHDs did not identify CAP as a primary focus, and one LHD reported two CAP partnerships. Overall, seven percent ($n = 69$ [of 924]) of partnerships reported by LHDs focused on CAP. The organizational characteristics of LHDs participating in CAPs are displayed in Table 1. There were no statistically significant differences between CAP partnerships and non-CAP partnerships on any organizational variables.

TABLE 1 ● Community assessment and planning partnerships by characteristics of local health departments

	Number	%
Jurisdiction		
Subdivision of county	27	39
County	42	61
Total	69	100
Structure		
Independent	53	77
Part of human service agency	16	23
Total	69	100
Geographic focus		
Urban/suburban	36	52
Rural	33	48
Total	69	100
State certification level*		
Level 1	12	17
Level 2	37	54
Level 3	20	29
Total	69	100

*Certification level is defined by Wisconsin state statutes and reflects extent of services provided by the local health department. Certification level correlates with mean population of area served. The 2000 population means for local health department jurisdictions in Wisconsin were as follows: Level 1 = 15,465; Level 2 = 42,693; Level 3 = 209,741.

Partnerships that addressed CAP as a focus area were most commonly formed to address a need in the community ($n = 48$, 70%), to meet a government mandate ($n = 44$, 64%), and to increase the likelihood of achieving desired results ($n = 38$, 55%). Approximately two thirds of CAP partnerships (66%) had existed for three or more years. The most common geographic area targeted by CAP partnerships was the county (57%).

The mean number of types of organizations in CAP partnerships was 8.1 (range = 1–17). The most frequent organizations engaged in these partnerships were government agencies (78%), hospitals (78%), community-based organizations (72%), businesses (68%), K-12 schools (67%), and individuals (67%). The activities in which CAP partnerships engaged are displayed in Table 2.

Approximately half of the CAP partnerships (51%) reported having a budget. Most partnerships that addressed CAP (85%) reported few or no partners contributing financially to the partnership. The most common types of financial support by LHDs for CAP partnerships were in-kind staff only (78%), cash pass through to the partnership from a grant or other source (49%), in-kind support other than staff (40%), and cash from the LHD budget (26%). Only 6 percent of CAP partnerships did not receive financial support from the LHD.

CAP partnership effectiveness

Seventy-nine percent of CAP partnerships reported implementation of at least some partnership plans. Bivariate analyses were conducted to examine the influence of partnership variables on implementation. All CAP partnerships existing 3 years or more ($n = 43$) had implemented plans, compared to 43 percent ($n = 10$) of partnerships existing less than 3 years. There were no significant findings in logistic regressions of the likelihood of implementation of partnership plans on partnership and organizational variables.

Seventy percent of CAP partnerships that reported implementation of at least some partnership plans indicated the extent of success in their plan implementation was very or generally successful (mean = 3.23, SD = 0.64). Bivariate and multivariate analyses were conducted using extent of success in implementation of plans as an outcome. On bivariate analysis, CAP partnerships reported by LHDs in nonrural areas were significantly less successful than CAPs in rural areas; however, this effect did not hold in multivariate models using all partnership and organizational variables. There were no other significant findings in bivariate and multivariate models of success.

Comparison of CAP to other types of partnerships

The mean number of types of organizations included in CAP partnerships was 8.1, compared to a mean of 5.15 for all non-CAP partnerships (range = 1–18). This difference in mean number of types of organizations was statistically significant on ANOVA analysis ($F = 49.77$, $df = 1$, $p < .00001$). In addition, 16 of 17 types of partnering organizations were significantly more likely to be included in CAP partnerships compared to all other types of partnerships (Pearson χ^2 tests, $p < .04$).

TABLE 2 ● Comparison of activities by partnership type

	CAP*		Non-CAP			
Activity	*n*	%	*n*	%	χ^2	*p*
Community assessment	66	96	311	36	92.367	<.000
Goal-setting activity	57	83	372	44	38.911	<.000
Networking/information sharing	55	80	718	84	0.985	.321
Creating action plans	52	75	485	57	8.923	.003
Disseminating information	51	74	639	75	0.040	.841
Influencing policy	49	71	319	37	29.989	<.000
Addressing state health plan	45	65	351	41	15.026	<.000
Conducting community events	27	39	371	44	0.507	.477
Designing systems	24	35	211	25	3.370	.066
Providing direct services	16	23	484	57	29.072	<.000

*CAP indicates community assessment and planning partnerships.

The activities reported by CAP partnerships also differed from those reported for all other partnership types. Table 2 compares activities reported by CAP partnerships with activities of partnerships focused on other problems or issues. CAP partnerships were significantly more likely than non-CAP partnerships to engage in half of the activities. Non-CAP partnerships were significantly more likely than CAP partnerships to engage in only one activity, providing or coordinating direct services to clients.

Participating LHDs were asked to indicate how many of their partnering organizations contributed financial resources to partnership activities. Compared to non-CAP partnerships, a greater percentage of CAP partnerships reported few or no partners contributing financially to partnership activities, but this difference was not statistically significant.

The financial contributions of LHDs to partnerships were also examined. A greater percentage of LHDs in CAP partnerships provided some form of financial support to the partnership than LHDs engaging in other partnerships. This difference approached statistical significance (*2-sided Fisher's exact* = 0.064). Compared to LHDs engaging in other partnerships, LHDs in CAP partnerships were more likely to provide two particular types of financial support. A significantly greater percentage of CAP partnerships reported cash pass through ($\chi^2 = 5.313$, $df = 1$, $p = .021$) and cash from the LHD ($\chi^2 = 5.057$, $df = 1$, $p = .025$) compared to non-CAP partnerships.

The percentage of partnerships that were initiated because of a mandate was significantly higher for CAP partnerships than non-CAP partnerships (Pearson $\chi^2 = 109.032$, $df = 1$, $p < .000$). There were no statistically significant differences at the 95 percent confidence level between CAP partnerships and non-CAP partnerships by any other reason formed. Finally, there were no statistically significant differences between CAP partnerships and non-CAP partnerships on implementation and success in implementing plans.

Discussion

Local public health departments in Wisconsin almost universally engage with other community organizational partners in the core function of CAP. This finding is consistent with national survey data.[5] Wisconsin state statutes mandate that LHDs conduct CAP on a regular basis.[17] However, the formation of partnerships to conduct CAP is not required by statute. The most frequent reason for CAP partnership formation, "to address a need in the community," demonstrates a belief that community partners are necessary to CAP processes and products. The state mandate for CAP is reflected in the finding that CAP partnerships were more likely than partnerships focused on other issues to have been formed because of the mandate. While state policies requiring CAP may help ensure that LHDs provide this core function, health departments clearly value partnerships in the process of identifying community needs.

The breadth of partner organization types identified in this study was greater than that previously reported for LHD partnerships.[16] This may reflect the influence of supportive state-level activities partially funded by the Robert Wood Johnson Foundation Turning Point Initiative that resulted in the creation of a state health plan that includes partnerships as a foundational concept.[3] It is also possible that LHDs have incorporated the use of CAP guidelines, such as MAPP,[15] which include engaging partners as a specific step in the community assessment process. However, the extent to which agencies in Wisconsin use these types of planning processes has not been documented. The greater breadth of partner types found in CAP partnerships compared to those focused on other issues may be explained by the fact that many organizations generate data and hold perspectives that contribute to community assessments. In addition, many organizations benefit from the products of CAP. Thus, more organizations are likely to have incentives to participate in CAP partnerships than those focused more narrowly. Individuals were reported to be relatively frequent partners in these CAP partnerships. However, information on the type or extent of individuals' contributions, as distinct from contributions as organizational representatives, to CAP partnerships has not been described in the literature.

While all partnerships commonly reported networking and disseminating information activities, CAP partnerships were more likely to set goals, create action plans, influence policy, and address state health plan objectives. This demonstrates a relationship between the purpose and process of a partnership. Public health professionals with responsibilities for CAP working in LHDs must have the knowledge and skills needed to participate in these specific types of activities. Recently published recommended core competencies for the public health workforce also include these types of skills.[19]

LHDs contribute significant resources to CAP partnerships and may be their sole source of financial support. This may reflect a perspective that of all organizations in a community, the LHD holds the primary responsibility for CAP. This may be due to the mandate for CAP found in state statutes[17] and to the well-accepted role for public health agencies with regard to public health core functions and essential services defined by the Institute of Medicine.[1] Detailed information on the financing of this core function in Wisconsin is not currently available.

Importantly, most of these CAP partnerships reported a high degree of success. Partnership strategies for accomplishing CAP seem to be working in Wisconsin. However, there clearly was a positive relationship between time in existence and success. Since partnership processes are often time intensive[20] and CAP is a complex process, CAP partnerships should be supported for significant periods of time if success is to be expected.

Future research is needed to understand the life course of CAP partnerships and how the progression of CAP partnerships from assessment to plan can be accelerated. More information on the financial aspects of CAP partnerships and contributions of partner organizations to CAP would be helpful to managers of LHDs and other community organizations. While public health workforce competencies related to CAP are well-described, the extent to which educational programs stress skill development for partnership activities and the best practices for such skill development are still in need of evaluation. Finally, research that uncovers links between CAP partnership success and population health outcomes would help to demonstrate the value of using partnership strategies to improve public health.

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